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{I 000}	INITIAL COMMENTS A follow-up licensure survey was conducted on May 9, 2007 to verify compliance with the regulations cited in the February 8, 2007 deficiency report. The survey findings were based on observations, interviews with direct support and nursing staff and residents as well as record verification. At 6:33 AM, management was notified by telephone that a survey was in progress; however, no staff with supervisory authority was made available to facilitate the survey prior to its conclusion at 6:15 PM. Deficient practices remained unabated, as evidenced throughout the following report.	{I 000}		
{I 043}	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure that one of four residents with modified diets had been reviewed at least quarterly by the consulting dietitian. (Resident s#1, #2, and #3) The finding includes: 1. Resident #1's January 2007 physician's orders and annual nutritional evaluation indicated that she was prescribed a Low-fat, Low Cholesterol diet. Review of Resident #1's records failed to show evidence that a dietitian or nutritionist had reviewed her diet plan at least quarterly.	{I 043}	#1. Nutritionist will review clients records and Prog. Director will monitor facility Quarterly to ensure ~~of~~ quarterly review of nutrition	6-30-07

Mickae Warren

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Program Director

(X6) DATE 6-15-07

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{I 043}	Continued From page 1 2. Resident #2's February 2007 physician's orders and annual nutritional evaluation indicated that he was prescribed an 1800-Calorie diet. Review of Resident #2's records failed to show evidence that a dietitian or nutritionist had reviewed her diet plan at least quarterly. 3. Resident #3's February 2007 physician's orders and annual nutritional evaluation indicated that he was prescribed an 1800-Calorie diet. Review of Resident #3's records failed to show evidence that a dietitian or nutritionist had reviewed her diet plan at least quarterly. ********** 5/9/07 Not abated. There was no documented evidence that the GHMRP had secured services from a licensed Nutritionist.	{I 043}	#2. see 1043 #1 #3. see 1043 #1	6-30-07 6-30-07
{I 050}	3502.8 MEAL SERVICE / DINING AREAS Each GHMRP shall serve meals for all residents, including residents who are mobile, non-ambulatory, in dining areas unless otherwise temporarily required for health reasons. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on observation and interview the Group Home for persons with Mental Retardation (GHMRP) failed to serve all the residents meals in the facility's dining area.	{I 050}	House Mgr. [redacted] will monitor residents during meal-time to ensure residents dine in dinning room. addition—	6-30-07

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{I 050}	Continued From page 2 The finding includes: On February 7, 2007 at 12:13 PM, Residents #1 and #3 were observed to eat their lunch at a small breakfast table in the kitchen. Staff interview on the aforementioned date revealed that the clients eat in the kitchen because they "make too much mess." Further observations on the aforementioned date at 6:01 PM revealed Residents #1 and #3 also eating their dinner at a breakfast table in the kitchen. ********** May 9, 2007. Not abated. On May 9, 2007, Residents #1 and #3 ate their breakfasts at the small table in the kitchen while their three peers ate at the dining room table. When asked why they ate separately, the direct support staff person on duty that morning stated that this was a routine practice and that although she had asked about it in the past, supervisors had never offered an explanation.	{I 050}	Cont. ally the table in the kitchen was removed.	6/30/07
{I 057}	3502.15 MEAL SERVICE / DINING AREAS Menus shall be written on a weekly basis, shall provide a variety of foods at each meal, and be varied from week to week and adjusted for seasonal changes. This Statute is not met as evidenced by: The February 8, 2007 survey findings included;	{I 057}	Nutritionist provided seasonal menu's that are posted. the nutritionist provided	

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{I 057}	Continued From page 3 Based on observation and interview, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure that menus were written on a weekly basis for five of five residents . (Residents #1, #2, #3, #4 and #5) The finding includes: Observation of the direct care staff preparing the dinner meal on February 7, 2007 at 4:37 PM revealed that the meal was prepared without a menu. Interview with the staff on the aforementioned date revealed they receive menus on a monthly basis, however, at the time of the survey, the group home failed to provide documented evidence of any menus. ********** 5/9/07. Not abated. Staff preparing the May 9, 2007 breakfast did not use a menu. She served the same food items that were documented as served the previous morning for breakfast. The staff person who prepared dinner that evening stated she was without a menu. She said she had prepared the dinner based on her knowledge and what foods were available at the time (turkey wings, mashed potatoes and mixed vegetables).	{I 057}	cont. staff training and [redacted] and House Mgr. will monitor weekly that the menu is updated and posted. If what is posted on the menu is not in the facility staff will notify P.C. and the P.C. will select another day on the menu and note it ~~on menu~~ in log book.	6/15/07

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{I 057}	Continued From page 4 The breakfast and dinner staff both indicated that they thought Spring menus were coming soon.	{I 057}		
{I 073}	3503.3(b) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (b) Clean comfortable pillow; This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on observation and staff interview the Group Home for persons with Mental Retardation (GHMRP) failed to ensure that residents are provided with comfortable pillows. During the environmental inspection on February 8, 2007, the GHMRP failed to ensure Resident #5 was provided with a comfortable pillow. The resident's pillow was observed to be flat. ********** 5/9/07. Not abated. On May 9, 2007, the same thin pillow was observed on Resident #5's bed. When asked about this later that morning, a direct support staff person showed this surveyor 5 new pillows that were stored in a basement closet. Further interview revealed that the GHMRP management had decided to wait on purchasing new bedding (bedspreads, etc.) before presenting the new pillows.	{I 073}	Please find enclosed weekly checklist that will be completed by P.C. and or House Mgr.. The checklist includes monitoring bedding, additionally the weekly checklist will be reviewed monthly by Program Director.	6/15/07

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{I 082}	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: The previous survey revealed the following: Based on observation and staff interview the Group Home for Mentally Retarded Person (GHMRP) failed to ensure that bathrooms be equipped with paper cups. The findings include: During the environmental walk-through on February 8, 2007 , the facility failed to provide paper cups for use in any of the bathrooms used by the residents.	{I 082}	see 1073.	6/15/07
{I 090}	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on observation, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure the interior of the group home was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable	{I 090}		

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{I 090}	Continued From page 6 odors. The findings include: Observations of the GHMRP 's environment on February 8, 2006 are as follows: Bathroom The first floor bathroom tile was chipped at the lower part of the wall. Living Room The radiator cover in the living room had peeling paint. Dining Room One of the dining room chairs was observed missing the piece of wood extending from each side to support the legs. Bedroom 1. There was a hole in the wall behind Residents #3 and #5's bedroom door. Additionally, the Residents closet door was soiled and dirty. 2. Resident #1's second dresser was off the track. Additionally, inspection of the resident's hygiene kit revealed the resident's soap did not have a protective cover.	{I 090}	Bathroom - tile on lower part of wall was replaced. Living room - radiator cover was painted Dining room - chair was removed. Bedroom - ① hole in wall repaired and door painted ② Dresser was repaired and soap container replaced. Additionally as indicated in 1073 a weekly checklist will be implemented and monitored by P.C. and House Mgr. to include housekeeping	6/15/07 6/15/07 6/15/07 6/15/07 6/15/07

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{I 090}	Continued From page 7 ********** 5/9/07. Not abated. 1. On May 9, 2007, inspection of the dining room table and chairs revealed there were 6 chairs; all 6 were of a matching set. One of the chairs had missing arm rests. At 5:24 PM, staff assisted Resident #3 into the chair with missing arm rests. As staff pushed the resident's chair forward towards the table, the front left leg of the chair buckled backwards. With the chair about to collapse, two staff took the resident by each arm and lifted her up. As they lifted, the leg fell off the chair and it tipped over. There was no evidence that the chair identified in the 2/8/07 survey was replaced on 4/13/07, as indicated in the Plan of Correction dated 4/2/07. 2. On May 9, 2007, the microwave oven in the kitchen was inoperable.	{I 090}	#1. chair was removed. #2. Microwave was not plugged in and it is operating.	6/15/07 6/15/07
{I 103}	3504.10(e) HOUSEKEEPING Each GHMRP shall provide clean linens as follows to each resident at least weekly: (e) One (1) wash cloth. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on observation and staff interview the Group Home for Mentally Retarded Person (GHMRP) failed to ensure clean linens for Resident #3.	{I 103}		

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{I 103}	Continued From page 8 The finding includes: During the environmental inspection, Resident #3's wash cloth was observed to be soiled and bleached.	{I 103}	Wash cloth was replaced and will be monitored by weekly checklist see 1073.	6/15/07
{I 229}	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on staff interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure each employee with initial and continuing training that enables the employee to perform duties competently for one of four clients residing in the facility. (Resident #1) The finding includes: Observation on February 7, 2007 revealed Resident #3 appeared to be obese and was prescribed. The direct care staff was asked if the resident was on a special diet and after hesitating she said no, "they just can't have fried foods. Review of the resident's physician's orders dated December 2006 revealed she had been prescribed a Low Cholesterol-Low Fat -High Fiber, Soft Texture Chopped diet. Review of the GHMRP's training records revealed	{I 229}	see 1057. Additionally staff will initial that the boost supplement is given as recommended.	6/15/07

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{I 229}	Continued From page 9 that the most current training in nutrition was held on February 17, 2006. ********** 5/9/07. Not abated. On May 9, 2007, the staff person who prepared breakfast did not follow Resident #3's meal plan/ prescribed diet and Resident #1 was not given her prescribed nutrition supplement (Boost) before she left for day program. Although the Program Coordinator had documented providing staff training on 4/13/07, there was no agenda available for review that outlined what was discussed at the "Meal Service" training. The staff person had signed an attendance sheet; however, there was no evidence that the training had been effective to ensure that residents received proper nutrition.	{I 229}		
I 390	3520.1 PROFESSION SERVICES: GENERAL PROVISIONS Each resident of a GHMRP, regardless of his or her age or degree of disability, shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan in accordance with the current " Outcome Performance Measures " from the " Council on Quality and Leadership in Support for People With Disabilities " (Council) and to the extent of funds appropriated for purposes of D.C. Law 2-137, as amended. This Statute is not met as evidenced by: Based on observation, interview and record verification on May 9, 2007, the GHMRP failed to provide dietary and nursing services required to	I 390		

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I 390	Continued From page 10 meet the needs of its residents, as evidenced by the following: 1. Cross-refer to I043. There was no evidence that the GHMRP made available a licensed nutritionist or dietitian to monitor specialized diets and establish appropriate menus. Both Residents #1 and #3 had modified diets; Observations the morning of May 9, 2007 revealed that Resident #3's meal plan was not followed and Resident #1 did not receive the prescribed nutritional supplement (Boost) as ordered. There were no menus available for staff and the residents' records did not reflect quarterly review by a nutritionist, as mandated by this statute. 2. Resident #3 was obese and had several other health conditions. Her records, however, did not reflect a Health Management Care Plan. One of her conditions was periodic diarrhea. There was no evidence that the medical team had established a strategy for addressing potential diarrhea. It was noted, however, that she was on a lactose-free diet, to address a diagnosis of lactose intolerance. 3. Resident #3's Annual Nursing assessment, dated 1/1/07, did not indicate a current body weight. Instead, there was a weight recorded in July 2006. The GHMRP failed to ensure a comprehensive nursing assessment. As noted above, Resident #3 was obese and on a modified diet. 4. Cross-refer to I479. Interviews with the LPN Coordinator followed by record review revealed that Resident #3 had been sedated prior to medical appointments on April 6, 2007, May 3, 2007 and May 8, 2007. Review of the resident's	I 390	#1. see 1043. 6/15/07 #2. RN (STAFF NURSE [redacted]) will implement HMCP and monitor and revise quarterly. Additionally, RN will provide supervision of LPN's, TME's and DCA staff, providing training and monitoring of all documentation. #3. see 1390 #2. 6/15/07	

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I 390	Continued From page 11 Medication Administration Records (MARs) revealed that the sedations with Haldol 5 mg and Ativan 3 mg had not been properly documented on her MARs. There was no evidence that the consultant RN with supervisory authority over this GHMRP had reviewed Resident #3's April 2007 MAR to ensure accuracy. 5. The consultant RN with supervisory authority for this GHMRP was interviewed by telephone on May 9, 2007, between 12:22 PM and 12:40 PM. At approximately 12:38 PM, she said that the agency had some trained medication employees (TMEs); however, she stated that they did not use any TMEs at 815 Floral Pl. At 5:50 PM, however, a gentleman arrived at the GHMRP. One of the stated purposes for his visit was to administer medications that evening. Further interview revealed that he was a TME who had received training and supervision from another RN employed by the agency. There was no evidence that the consulting RN for this GHMRP was effectively monitoring and coordinating the residents' health care services.	I 390	#4 see 1390 #2.	6/15/07
			#5. see 1390 #2.	6/15/07.
{I 420}	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to provide habilitation and training to one of the three residents's in the	{I 420}		

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{I 420}	Continued From page 12 sample. (Resident #1) The finding includes: The GHMRP failed to provide habilitation and training for Residents #1 and #3 as evidenced below: 1. Interview with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP) on February 7, 2007 at 2:04 PM revealed that Resident #1 did not have any " goals, they just ask her what she wants to do." Interview with the direct care staff on the aforementioned date at 4:13 PM revealed Resident #1 dislikes and will refuse to go to the bathroom, she is able to bathe herself, but refuses, and she also refuses to brush her teeth. Further interview with the staff revealed the client will start brushing her teeth and then she will stop, and say she needs help. " Sometimes she wants people to feed her and will sit for a very long time. We encourage her to feed herself but sometimes we have to feed her. " According to the staff " we don't work on any programs, we use to, but now, she refuses." 2. Observations on On February 7, 2007 at 11:37 AM revealed Resident #3 sitting at the kitchen table looking through a magazine. At 12:13 PM, Resident #3 was observed to eat her lunch in the kitchen with Resident #1. At 2:31 PM, Resident #3 was observed to be still sitting in the kitchen and she returned to looking through her magazine. At 2:45 PM a direct care staff was observed sitting in the kitchen with the resident describing different things as she turned the pages of the same magazine.	{I 420}	#1. P.C. conducted staff training on ISP goal implementation for resident #1 and #3. Additionally P.C. will monitor records weekly and Prog. Dir. will monitor quarterly. #2. see 1420 #1.	6/15/07 6/15/07

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(I 420)	Continued From page 13 At 2:55 PM, the staff informed the surveyor that Resident #3 was blind in one eye and she likes to look at magazines. According to the staff, the resident can see shadows, and if she were to tell her what is in the picture she might smile. At 3:30 PM, Resident #3 was observed to be still sitting in the same spot in the kitchen, looking through that the same magazine. At 4:37 PM, Resident #3 continued sitting in the kitchen and began watching the staff prepare dinner until 5:25 PM when the meal was served. At 6:16 PM, Resident #3 was observed to go to the basement and received her medication. The resident was observed to return upstairs to the first floor and immediately proceeded to the second floor. At 6:35 PM, Resident #3 was observed in her bed. The direct care staff was observed in the basement dancing with the other residents. According to the staff she went upstairs three times to attempt to engage the resident in dancing with her housemates, but the resident refused. At the time of the survey the GHMRP failed to engage Resident #3 in any active treatment. [Also 3521.3] ********** 5/9/07. Not abated. On May 9, 2007, the residents were observed in the GHMRP from 6:25 AM - 8:21 AM and from 3:11 PM - 6:15 PM. Neither Resident #1 or #3 was observed engaged in training programs. Resident #3's Individual Support Plan (ISP) included a Speech/Language assessment, dated 1/27/07, that included 4 recommendations	(I 420)		

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{I 420}	Continued From page 14 training programs to improve expressive communication, as follows: "...direct intervention is recommended for 2 sessions every week... 1. ... correctly identify simple objects and pictures in her environment... 2. ... demonstrate the ability to produce simple sign symbols... 3. ...: use a communication book to initiate interaction..., 4. ... identify simple numbers and letters of the alphabet." Observations and interviews with the direct support staff that afternoon revealed no evidence that any of the 4 programs were implemented. Review of Resident #3's program book revealed that staff were collecting data on an outdated communication program (from the 6/05 ISP, expired 6/06) for her to identify her name from a list of names. Data had been collected 3 times a week until 5/2/07. (Note: No data was recorded on 5/7/07 or 5/8/07, as scheduled.)	{I 420}	P.C. has implemented the speech & language recommendations. A picture book has been developed to be use to initiate communication and she has a training goal to identify numbers and letters.	6/30/07
{I 422}	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on observation, interview, and record review, the Group Home for persons with Mental Retardation (GHMRP failed) to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s) (IHP) for one of three residents included in the sample. (Residents #3) The findings include:	{I 422}		

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{I 422}	Continued From page 15 1. Review of Resident #3's habilitation record on February 8, 2007 revealed the resident had an objective to gather plastic cups and utensils to set the table. At the time of the survey, the GHMRP failed to allow the resident the opportunity to engage in this program. 2. The GHMRP failed to design an Individual Program Plan (IPP) to address recommended targeted behaviors for Resident #3 as evidenced below: a) Interview with the direct staff on February 7, 2007 revealed that the Resident #3 has a Behavior Support Plan (BSP) to address placing soiled toilet paper in her bra and socks. The BSP requires to document all occurences. The facility designed a procedure to collect behavioral data at the day program via a communication book. The staff indicated that the client sometimes comes home with toilet paper in her chest, pants and her socks. "In the beginning we started sending the book to the day program and they sent it home for approximately three days. So we have to check everyday when she comes home from the day program. Review of Resident #3's habilitation record on February 8, 2007 revealed a Behavior Support Plan (BSP) dated March 1, 2006. According to the BSP the GHMRP was instructed "to check daily with the day program through the communication book to determine if the client engaged in paper stuffing at the day program and if so, make a note of the interventions they used to prevent this behavior. At the time of the survey the GHMRP failed to ensure that the aforementioned recommendations were implemented to assist the resident in training in	{I 422}	#1. See 14/20 #1. #2. P.C. has implemented the BSP steps for resident #3 target behaviors and has observed staff in following those steps. The target behavior data collection has been inserted and monitored by P.C. weekly and Prog. Dir. quarterly.	6/15/07 6/15/07

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{I 422}	Continued From page 16 accordance with her BSP. b) Further review of the resident's BSP revealed she exhibits aggression, non-compliance with medical procedures and toilet/tissue stuffing. The GHMRP failed to provide evidence of objectives to reflect the aforementioned targeted behaviors. ************************************** 5/9/07. Not abated. 1. On May 9, 2007, Resident #3 left the facility for her day program without a backpack. Interview with the morning staff person indicated that the resident's backpack was not in the GHMRP. Resident #3's Behavior Support Plan (BSP) had been updated, effective 3/10/07. Review of the updated BSP revealed that it still included the use of a communication book between the day program and group home. When interviewed by telephone at 3:36 PM, the day program Activity Coordinator (AC) confirmed that the resident was without a backpack. When asked about a communication book, the AC stated that the classroom staff who worked daily with Resident #3 had not seen a communication book "since December." The AC further indicated that while the resident's BSP stated that she was stuffing tissue paper into her undergarments during the day, while she was at day program, day program staff were reporting that she arrived at the program some mornings with the paper already in her undergarments. Review of the BSP revealed that the Social Worker/ Behavior Specialist who had written the plan misidentified the resident's day program.	{I 422}	# Communication book has a daily log that staff initial that the book went to day Program and again that the book came back to facility. If the book doesn't come back to facility Staff notify P.C. who contacts day Program to Locate book.	6/15/07

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{I 422}	Continued From page 17 There was no evidence that the Program Coordinator/QMRP had reconvened the interdisciplinary team to discuss the discrepancies. 2. There was still no evidence that the GHMRP provided Resident #3 with training objectives to address her non-compliance with medical appointments. Her previous BSP had only advised staff to tell the resident calmly in advance that she was going on an apointment; there were no other training strategies or training objectives included. The revised BSP ceased further references to training and instead, reflected the use of chemical restraints (sedation) prior to medical appointment. 3. Resident #1's Individual Support Plan (ISP) and physician's orders prescribed Boost nutritional supplement 3 times daily, including at breakfast. On May 9, 2007, however, the resident was not given Boost supplement before leaving for day program.	{I 422}	#3 see 1229.	6/15/07
{I 429}	3521.6 HABILITATION AND TRAINING Each GHMRP Director shall arrange for each resident to be reevaluated and to receive an Individual Habilitation Plan, which is updated appropriately at least annually. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on staff interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to have a current ISP for one of the three residents in the sample. (Resident #1) The finding includes:	{I 429}		

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{I 429}	Continued From page 18 Interview with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP) on February 7, 2007 revealed Resident #1 had an Individual Support Plan (ISP) meeting on January 8, 2007. Review of the resident 's habilitation record on February 7, 2007 at 2:01 PM revealed an (ISP) dated January 11, 2006. At the time of the survey there was no documented evidence of an ISP for Resident #1 dated January 8, 2007. ********** 5/9/07. Not abated. On May 9, 2007, there was no evidence of an ISP for Resident #1. In the Plan of Correction (POC), the GHMRP stated they had no control on the preparation and receipt of the actual ISP document. They further indicated that they will send written request to the DDS case manager once the ISP has expired. The POC , however, failed to reflect any actions/strategies the facility will take to ensure that the decisions made by the interdisciplinary team at the annual ISP meeting (health care, training programs, etc.) are implemented promptly (with or without the actual ISP document on hand).	{I 429}	ISP was received on 6/13/07.	6/15/07
I 479	3522.6(e) MEDICATIONS The record for a resident ' s prescribed controlled substances shall include the following: (e) Each time the controlled substance is to be taken or administered.	I 479		

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I 479	Continued From page 19 This Statute is not met as evidenced by: The GHMRP failed to maintain resident Medication Administration Records to accurately reflect all medications being administered, as evidenced by the following: On May 9, 2007, at 7:74 AM, Resident #3 was observed walking slowly and unsteady as she left the GHMRP. As she went down the front steps towards the van that came to drive her to day program, the van driver asked if she was all right. The overnight direct support staff person informed the driver that Resident #3 had been moving slowly all morning. She thought it might be due to her "procedure yesterday." At approximately 8:30 AM, interview with the same staff person revealed that the resident had been sedated prior to a medical appointment on the day before the survey (May 8, 2007). She further indicated the the morning medication nurse had assessed her that morning and determined she could go to day program. At 9:12 AM, interview with the morning medication nurse confirmed that Resident #3 had been sedated the previous morning prior to a physical exam; "she got Haldol 5 mg and Ativan 3 mg." The nurse further indicated that she had sedated the resident similarly on April 6, 2007 and May 3, 2007 with the same medications and doses. Beginning at 9:32 AM, review of Resident #3's Medication Administration Record (MAR) revealed that the nurse had failed to document the administration of Haldol and Ativan on April 6, 2007, May 3, 2007 and May 8, 2006. At 10:23 AM, the nurse acknowledged that she had not properly documented the aforementioned sedations on the resident's April and May 2007	I 479	See 1390 #2.	6/15/07

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I 479	Continued From page 20 MARs. She further stated that she would enter "Late Notes" into the MARs to document the sedations. A few hours later, Resident #3's May 2007 MAR was reviewed, beginning at approximately 12:14 PM. It was observed that the nurse had made errors in making her late entries for the sedations. For example, the May 3 and May 8, 2007 entries were dated 5/8/07 instead of the current date (5/9/07). She had not written "Late Note" or otherwise indicated on the MAR that these were late entries. Further review revealed that she had not made a similar entry for the April 6, 2007 administration. Once that was brought to her attention, at approximately 12:18 PM, she made a late entry for April 6, 2007.	I 479		
(I 500)	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: The February 8, 2007 survey findings included: Based on observation, interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws. The findings include: 1. Facility staff failed to ensure resident privacy during personal care, for one of the three women	(I 500)		

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{I 500}	Continued From page 21 in the sample. D.C. Law 2-137, Section 6-1901(2) "Secure for each resident of the District of Columbia with mental retardation...habilitation as will be suited to the needs of the person, and to assure that such habilitation is skillfully and humanely provided with full respect for the person's dignity and personal integrity..." 1. Observations on February 7, 2007 at 11:50 PM revealed Client #1 sitting in the living room in a chair. Further observation revealed the client sitting on what appeared to be a Chux. Interview with the staff on the aforementioned date verified that Client #1 was sitting on a Chux. The client remained sitting on the Chux throughout the survey. According to the staff the client wears Adult Protective Undergarments (APU's) because of her incontinence. ********** 5/9/07. Not abated. On May 9, 2007, Resident #5 was observed sitting on a Chux on the living room sofa. Resident #1 sat on the edge of the Chux for a period of time, then Resident #5 sat on it again. The Chux remained on the sofa until the residents left for day program. 2. 5/9/07 Abated 3. Section 6-1961 (b) Habilitation care; habilitation program. The GHMRP failed to ensure habilitation, training and assistance was provided to its residents in	{I 500}	#1. P.C. has instructed staff on residents rights and the Chux are no longer being used in the living room.	6/15/07

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{I 500}	Continued From page 22 accordance with their Individual Habilitation Plan(s) (IHP) for one of three residents included in the sample. [See 3521.3] ********** 5/9/07. Not Abated. 4. Section 6-1962 Living conditions; teaching of skills The GHMRP failed to provide habilitation and training to one of the three residents's in the sample. [See 3521.1] ********** 5/9/07. Not Abated 5. Section 6-1964 Comprehensive evaluation and individual habilitation plan The GHMRP failed to ensure an annual Individual Support Plan (ISP) was provided for one of the three residents in the sample. [See 3521.6] ********** 5/9/07 Not Abated 6. Section 6-1965 Visitors; mail; access to telephone; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication. Interview with the nurse on February 8, 2007 at 11:27 AM revealed that Resident #3 was	{I 500}	#3 see 1420 #1. #4 see 1420 #1. #5. Received ISP for resident #1 on 6/13/07.	6/15/07 6/15/07 6/15/07

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{I 500}	Continued From page 23 non-compliant with medical appointments. Further interview with the nurse revealed that Resident #3 refused the following medical appointments evidenced below: - Annual physical examination on December 5, 2006 because the resident refused to get off of the van. -Podiatry on January 6, 2006 refused treatment - Mammogram on July 24, 2006 resident refused to cooperate -Dental on September 15, 2006 resident refused to open her mouth - Nutritionist on November 29, 2006 refused to see the Nutritionist The GHMRP failed to address the resident's non-compliance for medical appointments. 5/9/07 Not Abated. The GHMRP failed to document the use of less restrictive behavior intervention techniques prior to the use of drugs (sedation) before medical appointments, as follows: On May 9, 2007, Resident #3 appeared groggy as she walked towards the van that came to transport her to day program that morning. The overnight staff reported that she had been sedated the previous day with Haldol 5 mg and Ativan 3 mg prior to a medical appointment. There was no evidence that the GHMRP provided Resident #3 with training objectives to address her non-compliance with medical appointments. Her previous BSP had only advised staff to tell the resident calmly in advance that she was going on an appointment; there were no other training strategies or training objectives included. The	{I 500}	#6. Resident #3 has a BSP that has identified medical non compliance as a target behavior and the step identified in the BSP are being followed. Additionally the RN is exploring the possibility of having Doctor see resident #3 in home or nurses office.	6/15/07

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{I 500}	Continued From page 24 revised BSP ceased further references to training and instead reflected the use of chemical restraints (sedation) prior to medical appointment, without first attempting less restrictive techniques. It should be noted that the RN providing oversight of the GHMRP prepared an Annual Nursing assessment, dated 1/1/07, that documented the "uncoopperativeness and refusal of treatment(s)...still remains uncooperative..." The RN recommended the following: "I strongly feel <Resident #3> needs to be hospitalized to obtain a baseline on her actual health status..." Further review of the resident's medical chart failed to show evidence that the primary care physician had been made aware of the RN's 1/1/07 recommendation for hospitalization. 7. 5/9/07 abated 8. Section 6-1962 Living conditions; teaching skills According to the definition for D.C. Law 2-137 the "Normalization principle means the principle of aiding mentally retarded persons to obtain a lifestyle as close to normal as possible, making available to them patterns and conditions of everyday life which are as close as possible to the patterns of mainstream society.". 5/9/07. The deficiency cited regarding designated time for administering the morning medications was abated. On May 9, 2007, it was observed that none of the 5 residents was provided the opportunity (or encouraged to) rinse their breakfast plates and	{I 500}	#8 Prog. Dir. provided staff training on inclusion and normalization as indicated in the basic assurances outline on 5/11/07.	6/15/07

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{I 500}	Continued From page 25 beverage glasses in the kitchen sink and/or loading them into the dishwasher. Instead, they went to the sink, handed them to the staff person who then rinsed and placed them in the dishwasher. Interview with a longtime staff person (she worked with the residents 2 years ago) revealed that she thought that all 5 women had the skills and ability to rinse their dirty dishes and place them in the dishwasher. 9. There was no evidence that Resident #3's medical guardian had been asked to provide written consent for the use of sedation for medical appointments. Cross-refer to I479. On May 9, 2007, interviews with the morning medication nurse followed by record review revealed that Resident #3 had been sedated with Haldol 5 mg and Ativan 3 mg on April 6, 2007, May 3, 2007 and May 8, 2008, prior to medical appointments. At 11:59 AM, review of Resident #3's record revealed court documents, dated April 27, 2006, appointing a guardian for health care decisions. Further review of the record, however, failed to show evidence that the medical guardian had signed written consent forms for the use of Haldol and Ativan for sedation. 10. There was no evidence that the GHMRP had addressed ongoing requests from Resident #1, to ensure that her rights were protected. a. At approximately 7:15 AM, Resident #1 asked for a bowl of cereal. The direct support staff on duty reminded her that she couldn't drink milk. The resident indicted that she was aware that milk would cause stomach distress. Her discussion with the staff person indicated this was an ongoing issue. Resident #1 had a	{I 500}	#9. see 1390 #2.	6/15/07
			#10. See 1500 # B.	6/15/07

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{I 500}	Continued From page 26 diagnosis of lactose intolerance. Further interview, however, revealed that the GHMRP failed to make available lactose-free milk or an appropriate substitute to allow the resident the opportunity to have cold cereal as requested. b. At 7:59 AM, Resident #1 informed the direct support staff person (and this surveyor) that she missed a former housemate. She cited the former housemate's full name. Resident #1 returned from day program at 3:11 PM. Upon entering the facility, she again stated that she missed her former housemate. Staff indicated that she asked about the former housemate frequently. The resident said it had been "a long time" since they had seen one another. Further interviews with direct support staff revealed no evidence that the GHMRP had made efforts to contact the former housemate or otherwise tried to address the resident's friendship/ visitation rights.	{I 500}		